

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

SL 30621

63-018209

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4710

FILED MAY 9 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN 915 N. Grand, St. Louis, Mo.

Length of stay in 1b

50 days

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Warren

c. CITY

OR TOWN Marthasville

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS

(If outside, give location)

RT. # 3, BOX 73

Reside on Farm

Yes ☒ No ☐

3. NAME OF DECEASED

First

Middle

Last

(Type or print)

HERMAN

SCHWERDT

4. DATE OF DEATH

Month

Day

Year

April

28

1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

5/25/94

9. AGE (last birthday)

68

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Treloar, Missouri

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Herman Schwerdt

13b. MOTHER'S MAIDEN NAME

Henrietta Wehmeyer

14. NAME OF HUSBAND OR WIFE

Cora - - - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WW-1

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Gladys Landwehr (Daughter), Same add. as 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

HEMORRHAGE

INTERVAL BETWEEN ONSET AND DEATH

2 DAYS

DUE TO (b)

ACUTE LEUKEMIA

DUE TO (c)

2043

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

s.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. Attended the deceased from

3/9/63

to 4/28/63

and last saw him alive on 4/28/63

Death occurred at

12:35 A. M.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

VAH, ST. LOUIS, MO.

22c. DATE SIGNED

4/28/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

5-1-63

23c. NAME OF CEMETERY OR CREMATORY

City Cemetery

23d. LOCATION (City, town, or county)

Warrenton, Missouri.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Nieburg Funeral Home, Warrenton, Missouri.

25. DATE RECD. BY LOCAL REG.

APR 30 1963

26. REGISTRAR'S SIGNATURE

Earl Smith M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

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VS 300

Rev. 4/59

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SEP 17 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.